Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/20/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

SCS Trial

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Anesthesiologist; Board Certified Pain Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. The reviewer finds the requested SCS Trial is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determinations, 07/18/12, 07/30/12
Surgery scheduling slip/checklist 06/13/12
Behavioral medicine evaluation 07/02/12, 10/07/10
Office visit notes 06/13/12, 05/31/12, 05/03/12, 02/09/12, 01/19/12, 10/28/11, 05/12/11, 02/10/11, 01/20/11, 12/09/10, 09/24/10, 08/17/10
Designated doctor examination 08/16/10
Peer review 07/06/12
Neurophysiological consultation and report of electrodiagnostics 08/24/10
Post designated doctor medical examination 11/11/10
Handwritten physical therapy progress report 04/14/11
Operative reports, 01/25/12, 12/14/11, 01/25/11
Radiographic reports, 12/14/11, 05/12/11, 02/10/11, 01/25/11, 11/08/09, 11/03/09
On-call note 12/14/11
MRI lumbar spine, 05/10/12, 12/11/09

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is female. She was involved in a motor vehicle accident. She had 360 fusion at L5-S1 in January 2011. Note dated 10/28/11 indicates that she did very well initially after her lumbar fusion. Unfortunately, she is starting to deteriorate some, complaining of back pain in the area of the pedicle screw instrumentation. She had exploration of fusion, fusion augmentation and removal of hardwires on 01/25/12. Follow up note dated 05/03/12 indicates that the patient underwent physical therapy. She reports that she continues to have significant low back pain across her low back several times a week. MRI of the lumbar spine dated 05/10/12 revealed postoperative changes at L5-S1. The interdisc device has been placed. There appears to be good cortical union between L5 and S1. A large screw has been placed obliquely through L5 and S1 anteriorly. There is a ventral listhesis of L5 relative to S1 of approximately 6 mm. There is, however, no spinal stenosis. The facet articulations are overgrown but not producing any lateral recess stenosis or foraminal stenosis. She is taking Lyrica, Norco and Flexeril. On physical examination her upper and lower extremity strength is 5/5. She has tenderness across her lumbosacral spine. She has surgical incisions. She has no swelling in the arms or legs. Reflexes are intact.

A behavioral medicine evaluation dated 07/02/12 indicates that her scores on the MMPI-2-RF validity scales raise concerns about the possible impact of under-reporting on the validity of this protocol. The patient was cleared for the stimulator with a fair to good prognosis for pain reduction and functional improvement. Peer review dated 07/06/12 indicates that the documented diagnoses do not appear to be a direct result of the work-related injury. The claimant had a significant pre-existing spondylolisthesis. The spondylolisthesis was never determined to be her pain generator. Now that the spondylolisthesis is stabilized, the claimant's symptoms are exactly the same as they were. There has never been a physiologic diagnosis for her lower back pain. It is unlikely that the spondylolisthesis was aggravated in any fashion or made unstable in any fashion by the accident. There is no physiologic condition that would be the direct result of the work-related injury. No further treatment would be reasonable or necessary for the compensable work injury. The claimant is not a candidate for a spinal cord stimulator. Spinal cord stimulators are not indicated for axial back pain per ODG. There is no evidence of ongoing symptomatic radiculopathy.

On 07/18/12 the request for SCS was denied. The reasoning behind the denial was that the documentation submitted for review elaborates the patient complains of ongoing low back pain despite a previous surgical intervention. The Official Disability Guidelines recommend a spinal cord stimulator trial provided the patient meets specific criteria to include completion of a psychosocial evaluation. There is a lack of information regarding the patient's completion of a psychosocial evaluation addressing any confounding issues as well as potential outcomes of the impending surgery. The denial was upheld on appeal dated 07/30/12 noting that the documentation submitted for review did not note if the patient has undergone injections, anti-epileptic medications or TENS unit. In addition, guidelines state that the indications for a stimulator implantation are failed back syndrome, complex regional pain syndrome, post amputation pain, postherpetic neuralgia, spinal cord injury, pain associated with multiple sclerosis or peripheral vascular disease. The patient was not noted with any of those diagnoses. In addition, it is unclear if the patient has axial back pain or symptomatic radiculopathy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The patient is status post 360 fusion at L5-S1 in January 2011 with subsequent exploration of fusion, fusion augmentation and removal of hardwires on 01/25/12. There is no comprehensive assessment of postoperative treatment completed to date or the patient's response thereto submitted for review. Per peer review dated 07/06/12, the documented diagnoses do not appear to be a direct result of the work-related injury. The claimant had a significant pre-existing spondylolisthesis. The

spondylolisthesis was never determined to be her pain generator. Now that the spondylolisthesis is stabilized, the claimant's symptoms are exactly the same as they were. There has never been a physiologic diagnosis for her lower back pain. It is unlikely that the spondylolisthesis was aggravated in any fashion or made unstable in any fashion by the accident. There is no physiologic condition that would be the direct result of the work-related injury. No further treatment would be reasonable or necessary for the compensable work injury. The claimant is not a candidate for a spinal cord stimulator under the evidence-based guidelines. Spinal cord stimulators are not indicated for axial back pain per ODG. There is no evidence of ongoing symptomatic radiculopathy. The reviewer finds the requested SCS Trial is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)